

Disclosure of Ownership, Business Transactions & Exclusions Statement for Providers

I. Instructions

This statement must be submitted by the deadline set by the managed care organization (MCO). A new statement must be submitted when any information in your statement has changed.

You should complete this form in conjunction with review of the requirements for disclosure of ownership, business transactions and exclusions of individuals and entities from government programs as provided in the MCO's administrative requirements.

This statement must be completed whether or not you have any information to report. If more space is needed, please attach additional information.

For assistance in completing this statement, please reference the "Definitions" on page 5.

II. Identifying Information

Legal Name According to the IRS: _____

DBA: _____

Address: _____ NPI: _____

City: _____ State: _____ Zip Code: _____

Office Phone Number: _____

Federal Employer ID (FEIN): _____ Tax ID: _____

III. Structure

Check the entity that describes your structure:

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Corporation
- ☐ Non-Profit
- ☐ Other Partnership (i.e, LP, LLP, LLLP)

IV. Ownership & Control Interests

- A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you as a Provider have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name	Address	% of	SSN	Drivers License	Relationship
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			Owner Interest	or FEIN	No.	
1.						
2						
3						

- B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an “N/A.”

No.	Full Legal Name	Address	% of Owner Interest	SSN or FEIN	Drivers License No.	Relationship
1.						
2						
3						

- C. For each Person with an Ownership or Control Interest listed in subsection IV(A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such ownership exists, please indicate this with an “N/A.”

No.	Full Name of Business or Organization	Name of Other Organization	Address	SSN or FEIN	% of Ownership Interest
1.					
2					
3					

V. Significant Business Traction

- A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty-five thousand dollars (\$25,000) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists, please indicate this with an “N/A.”

No.	Name of Subcontractor	Address	SSN or FEIN	% of Owner Interest
1.				
2				
3				

- B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an “N/A.”

No.	Name of Wholly-Owned Supplier	Address	SSN or FEIN	Nature of Business Transaction
1.				
2				
3				

V. Excluded Individuals or Entities

- A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any of your Managing Employees, Agents or Subcontractors who have ever:

Been convicted of a criminal offense related to that person’s involvement in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and 1128A of the Social Security Act?

- ☐ Yes
☐ No

Been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

- ☐ Yes
☐ No

- B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan’s obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who has been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

- ☐ Yes
☐ No

If you answered “Yes” to any of the above questions, list the name and social security number or Tax ID of the individual or entity, and reason for answering “Yes” (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act).

No.	Full Legal Name	Address	SSN or FEIN	Reason
1.				
2				

VI. Certification

I certify that the above information is true and correct. I will notify the MCO of any changes to this information.

Name: _____ **Title:** _____

Signature: _____ **Date:** _____

Email Address: _____

For the purposes of this statement, the following definitions apply:

1. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider.
2. **Managing Employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the Provider.
3. **Ownership Interest** means the possession of equity in the capital, the stock, or the profits of the Provider.
4. **Person with an Ownership or Control Interest** means a person or corporation that:
A) has an Ownership Interest, directly or indirectly, totaling five percent (5%) or more in the Provider; B) has a combination of direct and indirect Ownership Interests equal to five percent (5%) or more in the Provider; C) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the Provider, if that interest equals at least five percent (5%) of the value of the property or assets of the Provider; or D) is an officer or director of the Provider (if organized as a corporation) or is a partner in the Provider (if organized as a partnership).
5. **Provider** means an individual or entity that has entered into an agreement with any of the health plans listed on page 4 of this statement and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.
6. **Significant Business Transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5% of the Provider's total operating expenses.
7. **Subcontractor** means an individual, agency, or organization to which the Provider has contracted or delegated some of its management functions or responsibilities of providing medical care to patients.
8. **Wholly Owned Supplier** means a supplier (i.e., an individual, agency, or organization from which a Medicaid provider purchases goods and services used in carrying out its responsibilities under Medicaid) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.